#### PRINTED: 01/25/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 155295 01/19/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST **CLINTON HOUSE HEALTH AND REHAB CENTER** FRANKFORT, IN 46041 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 This visit was for the Investigation of Complaint IN00084499. Complaint IN00084499 - Substantiated, federal/state deficiencies related to the allegation are cited at F-323 and F-514. Survey dates: January 13, 14, and 19, 2011 Facility number: 000192 Provider number: 155295 AlM number: 100291120 Survey team: DeAnn Mankell, R.N. Census bed type: SNF/NF: 69 RECEIVED Total: 69 Census payor type: Medicare: 13 FEB - 4 2011 Medicaid: 45 Other: 11 Total: LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH Sample: 3 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 1-24-11 Cathy Emswiller RN F 323 483.25(h) FREE OF ACCIDENT F 323 SS=G HAZARDS/SUPERVISION/DEVICES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

The facility must ensure that the resident environment remains as free of accident hazards

as is possible; and each resident receives

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ENTERED FEB

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PMZT11

Facility ID: 000192

If continuation sheet Page 1 of 27

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	
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		155295				01/1	9/2011
	PROVIDER OR SUPPLIER N HOUSE HEALTH AN	ID DELIAD OFFICE		ı	REET ADDRESS, CITY, STATE, ZIP CODE		
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F 323	Continued From pa	ge 1	F3	323			
	i	on and assistance devices to		<i>)</i>	This Plan of Correction is the center's creallegation of compliance.		
	by: Based on observation review, the facility far place and to change occurred to prevent included bruises, lact staples, skin tears, a fracture, for 2 of 3 re of 3 (Residents A arrangement of 3 (Residents A arrangement of 3 (Resident B's closs reviewed on 1/13/11 Resident B's diagnoulimited to, COPD (chasease), IDDM (insumellitus), HTN (hyper (arteriosclerotic hears is included to the complete of the complete	sed clinical record was at 2:06 P.M. ses included, but were not pronic obstructive pulmonary ulin dependent diabetes extension), ASHD at disease), depression, depression, definition of the disease of t			Preparation and/or execution of this plan does not constitute admission or agreeme provider of the truth of the facts alleged of set forth in the statement of deficiencies. Correction is prepared and/or executed so it is required by the provisions of federal and the policy of this facility to keep the resident environment as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents.  Resident A has been assessed by the IDT with an appropriate care plan developed and implemented address the resident's current safe needs. Resident B no longer reside in the facility.  Residents with a history of falls and/or at high risk for falls have the potential to be affected. The IDT will assess residents to determine fall risk potential and develop/implement individualized plan of care to address residents current safety needs as appropriate.	to ty the process of the plan of plety because and state law.  The plan of plety because and state law.  The plan of plety because and state law.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	100200		STF	REET ADDRESS, CITY, STATE, ZIP CODE	03/1	9/2011
CLINTO	N HOUSE HEALTH AN	ID REHAB CENTER		8	09 W FREEMAN ST FRANKFORT, IN 46041		
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F 323	not received a fraction of the "Side Rail Asse indicated low bed an not checked indicated not in place.  The "Fall Risk Asse indicated a total social assessment indicate represents HIGH RITHE "Medicare/HMC organization) Skilled dated 12/3/10 indicated 12/3/10 indicated 12/3/10 indicated Resident Is self-transfer in her the legs "gave out" of possible contributional circuit indicated she was be external head injury initiated were "vital sassessment."  The Post-Fall Docum 12/3/10 at 11:30 A.M. "swelling to the back."  The Physician's ordered order to "D/C (discower admits to Memory in the Memory in	essment" dated 11/30/10 and soft mat on the floor where ing these interventions were  ssment" dated 11/30/10 are of 18. The key for the ed "Total score above 10 SK."  O (health maintenance if Documentation Flow Sheet" ated Resident B was sted by request in the toilet.  Indition Report-Sustained or ed 12/3/10 at 2:50 A.M., is had a witnessed fall during a pathroom. The resident said The preliminary investigation ting factors relating to the fall metance related to this fall arefoot. The resident had an interest the said The prost-fall actions signs and neurological mentation Flow Sheet dated M., indicated Resident B had it of head."  ers dated 12/3/10 indicated an intinue) PT (physical therapy) therapy)" and a second order	F	323	Staff will be re-educated on falls management including selection appropriate safety measures to m the needs of the resident and updating the plan of care as necessary.  The DON and/or Designee will monitor during routine rounds to ensure that continued compliance obtained. This monitoring will be done through IDT rounds. This area will be reviewed weekly 5x week for one month, then weekly x4, then monthly through randor audits and IDT rounds. Results the audits will be reported month to the QA team for review. The committee will review ongoing.	e is e  y Fe n 20 hly	ebruary 16,

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 323	problem of "At risk (related to): Medica Cardiovascular medisorder, Cognitive safety awareness, Hx of falls. The int not limited to, keep verbal safety cues, (nothing marked). updated on 12/3/10 (Memory Care Unipt transfers et amb The "IDT (interdisoreview" form dated for "Safety Risk" had identified. "Review potentially in need wanderguard, chair checked. The "IDT notes/recommendarecurrence" section 12/3/10 Resident watated knees becafell backwards. No line through it) app During an interview 10:45 A.M. she indinstructed on safety she needed to use The "Fall Risk Assindicated a total scassessment indicarepresents HIGH R	for falls and inturies (sic) R/T ation: Diuretic meds, ads. Medical Factors: Seizure Impairment, Dementia, Poor Visual impairment, Weakness, terventions included, but were of call light within reach, Provide pressure sensor pad in The interventions were to with Pt. moved to MCU to Gait belt to be utilized for all bulation."  Impairment, Weakness, terventions were to call light within reach, Provide pressure sensor pad in The interventions were to with Pt. moved to MCU to Gait belt to be utilized for all bulation."  Impairment, post-occurrence and no new safety issue to safety devices in use or those related to this occurrence and no new safety issue to safety devices in use or those related to this occurrence had a larm, and bed alarm to of the form indicated "On was standing in front of toilet me weak & wouldn't hold er' (indicated by a circle with a arent injury"  In with the DON on 1/19/11 at icated Resident B was y and to use the call light when the bathroom.  The interventions were to be a circle with a province of 19. The key for the ted "Total score above 10 RISK."  O Skilled Documentation Flow	F 323			
	Sheet" dated 12/12	2/10 at 9:05 P.M. indicated				

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F 323	on the edge of her I end of bed attempti couldn't reach it sat CNA"  During an interview 10:48 A.M. she indicated a total social assessment indicate represents HIGH RI The "Change of Cor Suspected Fall" date indicated Resident I was sitting on the to head injury. She was had happened. The possible contributing and additional circuit was blank. The "po "neurological assess hospital."  The nurses' notes dindicated "Res. fell for the sat to the sat the same same sat the same same sat the same sat the same sat the same same sat the same same sat the same same same same same same same sam	ounding, resident was sitting bed. Resident then scooted to ng to reach her walker, of floor witnessed by  with the DON on 1/19/11 at cated there was no additional arding this fall.  essment" dated 12/14/10 ore of 20. The key for the ed "Total score above 10 ISK."  Indition Report-Sustained or ed 12/15/10 at 11:15 P.M., as had a witnessed fall as she silet. She had an external as unable to tell the staff what e preliminary investigation of g factors relating to the fall mstance related to this fall st-fall actions initiated were sment and transfer to the ated 12/15/10 at 11:15 P.M., forward from toilet. Hit head noted on scalp. Res. keeps	F	323				
		ers dated 12/15/10 indicated ) ER for eval (evaluation) et ."						
	admitted to the ER.	ated on 12/16/10 was She had a laceration to her sed with staples and she						

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	returned to the facil  The "Episodic Care 12/15/10 had a prot from toilet - witness 12/16/10 of "Res. fa goal was "Res. will I falling asleep while days. The intervent limited to, "Do not le Be sure alarms are Alarmed seatbelt to in room alone in w/o of her. Keep call lig bed pan @ noc (nig The physician's order for "May place res. w/c for safety r/"  The "IDT (interdiscip review" form dated for "Review potentia to this occurrence" if dementia. will attern Risk" had no new sa safety devices in use related to this occurrence in the safety devices in use related to this occurrence. "Resident was on to unable to intervene  The Fall Risk Care Fupdated on 12/20/10 for falls" The intervene	Plan: Post-Fail" dated olem of "sustained fall - fell ed." There was a notation of alls asleep @ anytime." The have no falls r/t (related to) sitting in chair/toileting X 90 ions included, but were not eave res. unattended in BR. on when in bed or w/c. be placed on w/c. When res. a keep bedside table in front th in reach. Encourage using ht)."  Pers date 12/16/10 indicated an e a self release belt alarm on the falls."  Dilinary team) post-occurrence 12/20/10 indicated the section I contributing factors related andicated the "resident has dx and self transfers." "Safety afety issue identified. "Review the or those potentially in need rence" had bed alarm and elt checked. Nite light and and written on the form. The endations/targeted plan to section of the form indicated ilet & fell forward, CNA	F	323			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 323	During an interview 10:50 A.M. she indi of the fall the CNA the resident had na sitting up on the toil The "Fall Risk Asse indicated a total social assessment indicate represents HIGH R.  The January 2011 Forders for "Pressure bed. Check placem written on 11/30/10 alarm on res wc for 12/16/10.  The nurses' notes dindicated "Res. alar res. room Writer for laying in blood Whappened. 'Res state her forehead hurt  Review of the ER notes and wound of face." Should be completed indicated at the C 1 "probable nondisplated (neck fracture)." State of the facility A.M., with LPN # 1,	with the DON on 1/19/11 at cated during the investigation old the DON she didn't know reolepsy and could fall asleep et.  Sesment" dated 12/21/10 ore of 20. The key for the ed "Total score above 10 ISK."  Physician's Orders indicated a sensitive alarm in we and ent & function every shift" first "May place a self release belt safety r/t falls" first written on lated 1/7/11 at 1:30 A.M. m sounding. Writer ran to bound res. on floor by bed riter asked res what ated she rolled out of bed'  otes dated 1/7/11 indicated mitted to the ER with "open e complained of neck pain. A on 1/7/11 of her neck (cervical vertebra 1) ored transverse dens fracture he was transferred to a d admitted for treatment.	F 323				
	being at risk for falls	and having fallen in the past					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	Resident A's diagnor limited to Parkinson psychosis, depressi anxiety, hypertension Resident A's daugh Resident A was observed at 1:09 P.M. She was staring into space, the front and the bas brakes on the wheer esident was rocking forward as she talked around the resident the floor next to the attached to it. The stalls. She answered	I record was reviewed on	F	323	DEFICIENCY		
	4/21/10, 5/22/10, 6/7/31/10, for the probinturies (sic) R/T (reantidepressants & a Parkinson's, unstea fall 4/3/10." The intenot limited to, "proviside effects of medsencourage use of cagait and balance, latoileting needs, proving the province of the pro	isk Care Plan" dated 3/29/10, 16/10, 7/8/10,, 7/23/10, olem of "At risk for falls and lated to) Medications: intianxiety, incontinence, dy gait, dementia, weakness, erventions included, but were de adequate lighting, monitor is, keep call light within reach, all light, monitor for unsteady os as ordered, assess ride verbal safety cues, keep is within reach, keep assistive		eri den erenere endem e remede gemen endemmen damantante per de dels de la colonia.			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ID REHAB CENTER	•	8	REET ADDRESS, CITY, STATE, ZIP CODE 09 W FREEMAN ST RANKFORT, IN 46041		
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F 323	non-skid footwear, I (dated 4/5/10), OT (dated 4/5/10), pres (d/c [discontinue] 4/areas as much as p visual checks x 3 da (dated 7/31/10), mo (dated 7/7/10), refer 7/7/10), staff instruct (added 7/7/10), and (with) gait belt et as	ge 8 reach - wheelchair, provide PT eval and treat if indicated eval and treat if indicated eval and treat if indicated sure sensor pad in bed, w/c (5/10), pt to stay in common ross (possible) (dated 8/1/10), eays & psych eval (evaluation) etion sensor alarm ankel (sic) erred to OT for w/c (dated eted to lay pt down after meals it Res. to amb. (ambulate) c esist x i (one) to et from meals to lock w/c brakes (added	F	323			
	indicated a total sco	essment" dated 8/10/10 ore of 19. The key for the ed "Total score above 10 ISK."					
·	Found on floor behi- alarm sounded, w/c	indicated: Resident fell at 3:30 P.M. nd w/c (wheelchair) when was tipped over. No crossed through a circle)					
	The physician's order for "back anti-	er dated 8/19/10 indicated an tippers to be placed on w/c."					
	The care plan for fa "back anti-tippers" o	lls had the addition of the lated 8/19/10.					
	Suspected Fall" date A had a suspected of wheelchair in her rowas activated. She	ndition Report-Sustained or ed 8/31/10 indicated Resident fall from her chair or om at 10:45 A.M. The alarm obtained a red area o the left side of her forehead.				į	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	Continued From pa	ge 9	F3	23			
	review" form dated the resident "fell fro alone. Alarm sound The "IDT notes/reco to prevent recurrence indicated "Pt. sitting observed standing upointing up) from what therapy r/t (related Therapy stated this	plinary team) post-occurrence 9/1/10 indicated on 8/31/10 m w/c while trying to stand ded, CNA witnessed res. fall. ommendations/targeted plance" section of the form in w/c in rm (room) et was up (indicated by an arrow /c alarm was sounding. Spoke It to) pt legs giving out. will be a chronic problem. Pt on program to et from dining					
,	intervention of "Res	ated 3/29/10 indicated the . to amb. (ambulate) c (with) (one) to et from meals." had i/10.					
	had the following on first written: "Motion sensor aları "Res. to ambulate w to and from meals." "Auto lock brakes to	rith gait belt and assist of one 7/15/10		The second section is a second section of the second section of the second section sec			
	orders to "1. D/C (di alarm to bed. 2. Pr	an's order dated 9/6/10 with scontinue) motion sensor essure sensitive pad to w/c et hing et placement Q. (every)					
	post-occurrence rev	interdisciplinary team) iew" form dated 9/9/10 which device in use was an dside."					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 323	Continued From pa	ge 10	F 323				
	indicated a total sco	essment" dated 9/23/10 ore of 18. The key for the ted "Total score above 10 ISK."					
	assessment dated was moderately important cues/supervision reassistance of one proom and hallway, toilet. She was assistance while standhelp. She was assistance was assistance who was a was assistance who was assistance who was assistance wh	(minimum data set) 9/29/10 indicated Resident A paired with poor decisions; equired. She needed extensive person to transfer, walk in the peat, dress, bathe, and use the pessed as being unable to ding, or sitting without physical pessed as having unsteady gait the past 31-180 days.					
	Suspected Fall" dat A had a suspected wheelchair in her ro assisted transfer. F	ndition Report-Sustained or ted 11/1/10 indicated Resident fall from her chair or som at 9:15 A.M., during an Resident A was leaning out of The alarm was activated. She					
	review" form dated leaning forward in c no sx (signs) of inju were "pressure sen on floor next to bed notes/recommenda	plinary team) post-occurrence 11/1/10 indicated " was chair, fell out, hit head on bed c ry." The interventions in use sitive alarm to bed/chair. Mat ." The "IDT tions/targeted plan to prevent of the form was blank.					
	10:00 A.M., she ind urinalysis and EEG after this fall. She v	with the DON on 1/19/11 at icated Resident A had a (electroencephalogram) done was treated for a urinary tract lts of the EEG dated 11/2/10					

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	PROVIDER OR SUPPLIER N HOUSE HEALTH AN	ID REHAB CENTER		809	ET ADDRESS, CITY, STATE, ZIP CO W FREEMAN ST ANKFORT, IN 46041		<u>-</u>
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F 323	were "Technically u excessive muscle/n The "Fall Risk Asse indicated a total sco assessment indicate represents HIGH RI The "Change of Col Suspected Fall" data Resident A had a standard wheelchair in her roself- ambulation/sel investigation of post relating to the fall arrelated to this fall interestivated. There was off" next to the alarm During an interview 10:10 A.M., she indicated the fallen. She told there alarm, gotten up, fall walked to the toilet with She indicated the fare-educate the residual to be (I) (independent of the "Fall risk care productional intervention checks x 3 days and (with) assist x i (one).	nsatisfactory EEG because of novement artifact."  ssment" dated 11/10/10  pre of 18. The key for the ed "Total score above 10 ISK."  Indition Report-Sustained or ed 11/11/10 indicated uspected fall from her chair or om at 11:10 A.M., during a f-transfer. The preliminary sible contributing factors and additional circumstance dicated the alarm was not as a notation of "resident shut in. She had no injuries.  With the DON on 1/19/11 at cated the facility investigation resident told the staff she had in she had turned off the len, and gotten up and where the CNA had found her cility's intervention was to ent to call for assistance.  Per dated 11/11/10 indicated indent) amb (ambulation) c  In lan" dated 3/29/10 had ons dated 11/11/10 of "visual ons da	F3				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	155295		D. VVIIV	<u> </u>	01/1	9/2011
	ROVIDER OR SUPPLIER  NHOUSE HEALTH AN	ID REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE	(X5) COMPLETION DATE
	found resident sitting over Three small elbow et base of new The "Change of Co Suspected Fall" data indicated Resident was the chair or w/c in he to adjust the t.v. volinvestigation of posteriating to the fall at related to this fall was apparent injuries.  The "IDT (interdiscinated for "Review safety of potentially in need for "The "Change of Co Suspected Fall" data indicated Resident was sounding to chair tipped over. adjust TV volume."  The "Change of Co Suspected Fall" data indicated Resident was found on the flopuddle of blood und was leaning over to	g on floor with w/c tipped reddned (sic) areas on each ck"  Indition Report-Sustained or ed 11/15/10 at 8:15 P.M. A had a suspected fall from er room while she was "trying ume." The preliminary sible contributing factors and additional circumstance as blank. The resident had no polinary team) post-occurrence 11/17/10 indicated the section levices in use or those elated to this occurrence:" had ritten in the blank. The "IDT tions/targeted plan to prevent of the form indicated g in rm. in w/c watching TV to pt was sitting beside the bed Stated she was trying to andition Report-Sustained or ed 11/26/10 at 12:15 A.M., A had a suspected fall from reaching for an object. The d. The resident had a transported to the ER. The in the form indicated "Resident for on (R) (right) side c a er her head. Res. stated 'I get a cough drop off the floor	F3			
	the trash can."	asked stated 'I hit my head of				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION NG	(X3) DATE S COMPL	SURVEY ETED
		155295	B. Wil	NG_		01/1	C 19/2011
	PROVIDER OR SUPPLIER	ND REHAB CENTER		8	REET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 13	F;	323			
		er dated 11/26/10 indicated. R for evaluation &tx.					
	"Returned from hos	ndicated 11/26/10 9:00 A.M. spital at 7:30 A.M. Sutures to 2.6 cm. laceration"					
	The physician's ord "Low bed c mat."	er dated 11/26/10 indicated,					
	Suspected Fall" data indicated Resident her chair or w/c in hobject. The alarm fremoved. The resident apparent injuries. If form indicated "Reson floor. Denies hit circle with a line through the indicated through the circle with a line through the indicated through through the indicated through the indicate	d. Resident stated 'I was					
	10:20 A.M., she ind make sure the resid	with the DON on 1/19/11 at icated the intervention was to lents trash can was within y had gotten the resident a					
		plan" dated 3/29/10 had an personal belongings within plan.					
, , , , , , , , , , , , , , , , , , ,	indicated a total sco	essment" dated 11/27/10 ore of 21. The key for the ed "Total score above 10 ISK."					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE S COMPL	
		155295	B. WIN	IG		01/	C 19/2011
	ROVIDER OR SUPPLIER  N HOUSE HEALTH AN	ND REHAB CENTER		809	ET ADDRESS, CITY, STATE, ZIP COI W FREEMAN ST ANKFORT, IN 46041	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 14	F3	23			
	Suspected Fall" dat indicated Resident sitting position from	ndition Report-Sustained or ted 11/30/10 at 4:00 P.M., A had a suspected fall from a her w/c reaching for an sounded. She had no					
	review" form dated for "Review safety of potentially in need roblank. The "IDT not plan to prevent recuindicated "On 11/30 fell forward from sit	plinary team) post-occurrence 12/1/10 indicated the section devices in use or those related to this occurrence" was res/recommendations/targeted urrence" section of the form 1/10 Resident sitting in w/c - ting position. Alarm was reg - no (indicated by a circle t)"					
	Suspected Fall" dat indicated Resident . her w/c during a sel	ndition Report-Sustained or led 12/8/10 at 5:00 P.M., A had a suspected fall from if-transfer in her room as she The alarm was sounding.					
	review" form dated for "Review safety of potentially in need of chair alarm and bed was "bed & chair ala" IDT notes/recomm prevent recurrence "Resident c (with) p (history of) falls N	plinary team) post-occurrence 12/9/10 indicated the section devices in use or those elated to this occurrence" had d alarm checked. The notation arm intact & activated." The endations/targeted plan to ' section of the form indicated oor safety awareness, h/o O (new order) to dc ive alarms & apply self seat belt."					

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPL	
		155295	B, WING		6	C 9/2011
•	PROVIDER OR SUPPLIER	ND REHAB CENTER	8	REET ADDRESS, CITY, STATE, ZIP CODE 09 W FREEMAN ST FRANKFORT, IN 46041	<u> </u>	3/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	order for "self relea The "Change of Co Suspected Fall" dat indicated Resident, her chair or w/c in h object. She lost he activated. She had The post-fall actions neurological assess re-education, reinfo assistance, and oxy The nurses' notes of indicated "Alarm sor room, res was laying stated she was trying on bed. The bed m  During an interview 10:30 A.M. she indicated that fall.  During a second inte 1/19/11 at 1:50 P.M additional information the 12/11/10 fall.  The "Fall Risk Asses indicated a total sco assessment indicate represents HIGH RI The "Fall Risk Asses indicated a total sco	er dated 12/9/10 indicated an sing alarm belt."  Indition Report-Sustained or red 12/11/10 at 2:03 P.M., A had a suspected fall from the room reaching for an arbalance. The alarm was skin tears on the left hand. It is initiated where "post fall sment, provided safety roed using call light for regen saturation measured."  Itated 12/11/10 at 2:03 P.M. unding when arrive in resign on floor on back. Resign to open blinds & fell back oved & she fell to the floor"  With the DON on 1/19/11 at cated she had not reviewed erview with the DON on she indicated she had no on regarding interventions for essment" dated 12/11/10 re of 16. The key for the ed "Total score above 10 SK."	F 323			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155295	B. WII			1	C 1 <b>9/2011</b>
	PROVIDER OR SUPPLIER	ID REHAB CENTER		8	REET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN 46041	j Oit	3/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	dated 12/22/10 indicassessed as being decision making wit cues/supervision re assistance of one p or chair to a standin the hallway, use the assessed as being stabilize with humar during transitions ar and a wheelchair fo The physician order "Order clarifications alarming mat @ bed placement q. (every alarm to wc, check	ninimum data set) assessment cated Resident A was moderately impaired for the poor decisions and quired. She needed extensive erson to transfer from the bed ig position, walk in her room or toilet, and bathe. She was "not steady, only able to a assistance for balance and walking. She had a walker	F:	323			
	Suspected Fall" date indicated Resident A her w/c in her room. of possible contribute and additional circum was blank. The resimpost-fall actions init safety re-education, assistance." There stated, 'I was being wheeles (sic) in my with the physician's order. Anti-tippers on resident in the state of the	ers dated 12/28/10 indicated					

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	MULTIPI ILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		155295	B. WI			01/	C 1 <b>9/2011</b>
	ROVIDER OR SUPPLIER	ID REHAB CENTER		809	ET ADDRESS, CITY, STATE, ZIP COL W FREEMAN ST ANKFORT, IN 46041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	potentially in need r pressure alarm, cha checked. The nota placed." The "IDT notes/recommenda recurrence" section "Resident was sittin observed on the flood baserved baser	devices in use or those elated to this occurrence" had air alarm, and bed alarm tion was "back anti tippers tions/targeted plan to prevent of the form indicated g in w/c in room prior to being or"  with the DON on 1/19/11 at cated she did not know what e back anti-tippers, but she not been on the wheelchair ad fallen and were placed after did 12/29/10 for the problem of inturies (sic) r/t medication: cardiovascular meds, pain ntidepressants, incontinence, dementia, poor safety ory) of falls." The ed, but were not limited to, ighting, keep call light within insteady gait and balance, ngings within reach, keep thin easy reach, provide of easy reach, provide of the problem of indicated, indicated, pressure sensor at at bedside when in bed. self-releasing alarm belt, auto culate to meals."	F	323			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
		155295	B. WI	√G		i .	C <b>9/2011</b>
	ROVIDER OR SUPPLIER	ID REHAB CENTER	<b></b>	8	REET ADDRESS, CITY, STATE, ZIP CODE 09 W FREEMAN ST RANKFORT, IN 46041	0111	9/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	"Low bed with mat" "Self releasing alarr 12/09/10, "Pt to be independe one" first written on "Anti-tippers rear of alarming mat @ bec placement q. shift, p wc, check placemen The "Change of Cor Suspected Fall" date indicated Resident / assisted to the bath statement on the for ambulating res. to Be balance et fell back, - causing red area 4 head"  The CNA assignmen indicated Resident / alarms" and she wa ADLs (activities of d not lock w/c when in Interview with DON indicated the CNA's resident's hall were of a gait belt for amt Review of the policy Gait Belt," dated 200 administrator on 1/1 "Policy It is the policy of this	first written on 11/26/10, m belt" first written on shelt" first written on shelt with a shelt was shelt was being room with a CNA. The shelt shelt was being room with a CNA. The shelt shelt was shelt was being room with a CNA. The shelt shelt was shelt was shelt was shelt with the sheet dated 1/13/2011 and the shelt was to have "bed & chair is to have "Assist of 1 for aily living) and Transfers do a rm (room).  On 1/19/11 at 10:45 A.M. shelt on the day shift on the inserviced regarding the use bulation.  and procedure for "Use of 108, provided by the 19/11 at 1:50 P.M., indicated:	F	323			
	control and balance residents who requir and transfer.	(by using a gait belt) e assistance with ambulation				:	

STATEMEN"	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. (X2) N	/IUI.T	IPLE CONSTRUCTION	(X3) DATE S	10/EV
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU			COMPLI	
			B. WII	NG			С
		155295	D. ***	T		01/1	9/2011
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CLINTO	N HOUSE HEALTH AN	ID REHAB CENTER			309 W FREEMAN ST FRANKFORT, IN 46041		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	CION	(V5)
PREFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION DATE
iAo			1740	•	CROSS-REFERENCED TO THE APPR DEFICIENCY)	UPRIATE	DAIL
F 323	Continued From pa	ge 19	F;	 323			
	Purpose						
	To help control and	balance resident during					
	assisted transfer or	ambulation."					
	Review of the "Falls	Management," dated					
:		ided by the administrator on			·		
	1/19/11 at 1:50 P.M "Purpose. To evalua	., indicated: ate risk factors and provide					
	interventions to min	imize risk, injury, and					
	occurrences Fall	Prevention Equipment may					
		mited to: Alarms, sensor mats, pads, non-skid mats, hand					
	rails, grab bars, trap	eze, adaptive equipment,					
		Regularly review, revise, and					
	falls and injuries"	effectiveness at minimizing					
	•						
	This federal tag rela	ites to complaint IN00084499.					
	3.1-45(a)(2)	+ 5 g					
	483.75(I)(1) RES		F 5	514			
SS=D	RECORDS-COMPL LE	ETE/ACCURATE/ACCESSIB			F514		
	las las				It is the policy of the facility to maintain clinical records on eac	h	
		intain clinical records on each			resident in accordance with	,,	·
		ice with accepted professional ices that are complete;			accepted professional standards		
		ted; readily accessible; and			and practices.	-	
j	systematically organ				Due to the passage of time there	ic	
	The clinical record n	nust contain sufficient		1	no opportunity to correct the	13	
		fy the resident; a record of the		į	documentation of fall	. ;	
	resident's assessme	ents; the plan of care and			circumstances related to past fall		
	services provided; the	ne results of any ning conducted by the State;		į	Resident B no longer resides in t facility.	inis (	
	and progress notes.	ing conducted by the State,		1	inclinty.		
	. •				Residents with a history of falls		
	This REOLIDEMEN	T is not met as evidenced			have the potential to be affected.	1	
ļ	THIS INCOUNCINEIN	i is not met as evidenced			The medical records will be		

		I DELIVIOLO			,	OMP IA	<u>U. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	MULTI HLDIN	PLE CONSTRUCTION G		SURVEY PLETED
		155295	B. WII	NG_		01	C /19/2011
NAME OF F	PROVIDER OR SUPPLIER			ОТГ	PET ADDRESS COTA OTHER STREET		710/2011
	N HOUSE HEALTH AN	ID REHAB CENTER		8	REET ADDRESS, CITY, STATE, ZIP CODE 09 W FREEMAN ST		,
				F	RANKFORT, IN 46041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	IX .	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 20	F:	514	reviewed to ensure current safet	v	
	by:	_		• • • •	measures are in place to meet th		
		and record review, the facility		į	need of the resident.	~	
	failed to have comp	lete documentation related to		i	need of the resident.		
	how falls occurred a	and the interventions put into		İ	The staff will be re-educated on	tha	
	place after the falls	occurred for 2 of 3 resident		!			
	with falls in a sampl	e of 3 (Residents A and B).		:	proper completion of forms and documentation and the updating		
					care plans. Fall documentation		1
	Findings include:			:	be reviewed the next business d		
	d Double (D)				in conjunction with daily round		İ
		sed clinical record was			in conjunction with daily founds	<b>).</b>	.
	reviewed on 1/13/11	1 at 2:06 P.M.			The DON and/or Designee will		į
	Resident R's disano	ses included, but were not			review fall documentation and f	ક <u>ે</u> 11	
	limited to COPD (ch	ronic obstructive pulmonary			care plans 5x weekly x one mor		
!	disease), IDDM (ins	ulin dependent diabetes			then weekly x1month, and then	,	
	mellitus), HTN (hype				monthly. The results will be		
	(arteriosclerotic hear	rt disease), depression.		:	reported weekly by the DON to	the	February 16,
	seizure disorder, and	d hypersomnia (narcolepsy			IDT team for review. Results w		2010
	[falling asleep rapid]	y and frequently]).			be also monitored monthly by (		2010
	The "Change of Cor	ndition Report-Sustained or			Committee and ongoing.		1
	Suspected Fall" date	ed 12/3/10 at 2:50 A.M.,		!			
	indicated Resident E	had a witnessed fall during a		:			
,	self-transfer in her b	athroom. The resident said		į			
į	her legs "gave out" 7	The preliminary investigation					
ĺ	of possible contribut	ing factors relating to the fall					
		nstance related to this fall		:			
		arefoot. The resident had an		:			
į	external nead injury.	The "post-fall actions					
ľ	assessment."	igns and neurological		į			
	accessifull.						į
	The "IDT (interdiscin	linary team) post-occurrence		!			
	review" form dated 1	2/6/10 indicated the section		:			
	for "Safety Risk" had	no new safety issue		i	•		
	identified. "Review s	safety devices in use or those		:			
!	potentially in need re	elated to this occurrence" had		:			
	wanderguard, chair a	alarm, and bed alarm					
	checked. The "IDT	·					!

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION IG	(X3) DATE SI COMPLE	
		155295	B. WII	NG_		1	C 9/2011
	ROVIDER OR SUPPLIER N HOUSE HEALTH AN	ID REHAB CENTER		8	REET ADDRESS, CITY, STATE, ZIP CODE 109 W FREEMAN ST FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 514	recurrence" section 12/3/10 Resident will stated 'knees becar fell backwards. No all line through it) apparent of the through it instructed on safety she needed to use the through of the through of the through of the through of the through of the through of the through of the through of the through of the through of the through of the through of the through of through o	tions/targeted plan to prevent of the form indicated "On as standing in front of toilet me weak & wouldn't hold er' (indicated by a circle with a arent injury"  with the DON on 1/19/11 at cated Resident B was and to use the call light when the bathroom.  O Skilled Documentation Flow (10 at 9:05 P.M. indicated bunding, resident was sitting bed. Resident then scooted to a reach her walker, of floor witnessed by  with the DON on 1/19/11 at cated there was no additional	F!	514	İ		
	2. Resident A's clini 1/13/2011 at 12:25 l	cal record was reviewed on P.M.					

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
			A. BU B. WII				С
		155295	D. VVII			01/1	9/2011
CLINTO	ROVIDER OR SUPPLIER			8	REET ADDRESS, CITY, STATE, ZIP CODE 109 W FREEMAN ST FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 514	Resident A's diagnor limited to Parkinson psychosis, depress anxiety, hypertension The "Change of Co Suspected Fall" dat A had a suspected wheelchair in her roassisted transfer. Finder chair and fell. The "IDT (interdiscince review" form dated leaning forward in conous (signs) of injures were "pressure sen on floor next to be donotes/recommenda recurrence" section. During an interview 10:00 A.M., she indurinalysis and EEG after this fall. She winfection. The result were "Technically unexcessive muscle/normal transfer in her roself-ambulation/selinvestigation of posterlating to the fall ar	oses included, but were not o's disease, dementia, atypical ion, restless leg syndrome, on, and migraine headaches.  Indition Report-Sustained or red 11/1/10 indicated Resident fall from her chair or rom at 9:15 A.M., during an Resident A was leaning out of the alarm was activated. She plinary team) post-occurrence 11/1/10 indicated "was hair, fell out, hit head on bed c ry." The interventions in use sitive alarm to bed/chair. Mat "The "IDT tions/targeted plan to prevent of the form was blank.  with the DON on 1/19/11 at icated Resident A had a (electroencephalogram) done was treated for a urinary tract ts of the EEG dated 11/2/10 insatisfactory EEG because of	F	514			
i	activated. There We	as a notation of "resident shut		1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
	155295	B. WIN			į.	C <b>9/2011</b>
NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND	REHAB CENTER		80	EET ADDRESS, CITY, STATE, ZIP CODE 19 W FREEMAN ST RANKFORT, IN 46041	1 01/1	9/2011
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
During an interview with 10:10 A.M., she indice had determined their fallen. She told them alarm, gotten up, falle walked to the toilet with She indicated the factore-educate the resident The Nurses' notes indicated the resident to the found resident sitting over Three small related to the state of necknown to the toler to adjust the t.v. voluminvestigation of possi relating to the fall and related to this fall was apparent injuries.  The "IDT (interdisciplinated for "Review safety de potentially in need related to the fall and recommendation of the section of the s	with the DON on 1/19/11 at stated the facility investigation resident told the staff she had a she had turned off the en, and gotten up and there the CNA had found her. sility's intervention was to ent to call for assistance.  dicated:  "Resident was sitting in w/c r walked by alarm sounded, on floor with w/c tipped eddned (sic) areas on each k"  dition Report-Sustained or d 11/15/10 at 8:15 P.M. had a suspected fall from r room while she was "trying me." The preliminary ble contributing factors additional circumstance is blank. The resident had no inary team) post-occurrence 1/17/10 indicated the section vices in use or those ated to this occurrence:" had ten in the blank. The "IDT ons/targeted plan to prevent	F 5	i14			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LTIPLE CONSTRUCTION (X3) DATE SURV COMPLETED		
		155295	B. WIN	G		01/1	C <b>9/2011</b>
	ROVIDER OR SUPPLIER	ND REHAB CENTER		809	ET ADDRESS, CITY, STATE, ZIP COD W FREEMAN ST ANKFORT, IN 46041	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 24	F 5	14			
	Suspected Fall" dat indicated Resident her bed in her room alarm failed to sour laceration and was hand written note o was found on the flipuddle of blood und was leaning over to when I fell.' When the trash can."  The physician's ord "Low bed c mat."  The "Change of Co Suspected Fall" dat indicated Resident. her chair or w/c in hobject. The alarm fremoved. The resident apparent injuries. If form indicated "Reson floor. Denies hit circle with a line thrediscolorations noted going after another	d. Resident stated 'I was					
	10:20 A.M., she ind make sure the resid	icated the intervention was to lents trash can was within y had gotten the resident a					
	Suspected Fall" dat	ndition Report-Sustained or ed 11/30/10 at 4:00 P.M., A had a suspected fall from a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		155295	B. Wil	1G		1	C 1 <b>9/2011</b>		
NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN 46041					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO THI DEFICIENCY)		SHOULD BE COMPLETION			
F 514	sitting position from object. The alarms apparent injuries.  The "IDT (interdisci review" form dated for "Review safety optentially in need r blank. The "IDT not plan to prevent recuindicated "On 11/30 fell forward from sitt activated & soundin with a line through it activated The "Change of Col Suspected Fall" datindicated Resident wher chair or w/c in hobject. She lost her activated. She had The post-fall actions neurological assess re-education, reinfor assistance, and oxy The nurses' notes dindicated "Alarm sour room, res was laying stated she was tryin on bed. The bed me	her w/c reaching for an sounded. She had no plinary team) post-occurrence 12/1/10 indicated the section devices in use or those elated to this occurrence" was es/recommendations/targeted irrence" section of the form //10 Resident sitting in w/c - ting position: Alarm was g - no (indicated by a circle	F	514					
	1/19/11 at 1:50 P.M.	erview with the DON on she indicated she had no in regarding interventions for							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 514			F s	514				
	the 12/11/10 fall.							
		ates to complaint IN00084499.						
	3.1-50(a)(1) 3.1-50(a)(2)							
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